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ABSTRACT

The prescriptive approach to treatment of post-traumatic stress disorder (PTSD) requires an accurate diagnosis. Many of the changes in the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III) and DSM-III-Revised (DSM-III-R) have proven quite helpful in the diagnosis of PTSD. The DSM-III-R includes specification of generic characteristics of traumatic stressors. The identification of symptoms are around these dimensions of stress responses: (1) re-experiencing avoidance; (2) numbing; (3) physiological arousal; and (4) the inclusion of symptoms specific to children. The next logical step, after identification, is to refine the definition of PTSD for children and adolescents and list PTSD appropriately with the other childhood anxiety disorders. This would serve the purposes of improving the diagnostic qualities and improving the research data base. The treatment of children should be individualized on the basis of the diagnostic criteria and the needs of children. This position needs to be advocated by professional counselors and therapists working with children and adolescents. A new PTSD and diagnostic procedure needs to be developed for children. The symptoms would be specifically designed for children and assigned with the other anxiety disorders listed under Disorders Usually First Evident in Infancy, Childhood or Adolescence, Chapter III, of the new DSM-IV. Research should be utilized to develop a conceptual approach that would meet the needs of children and adolescents and emphasize specific additional symptomatology. (ABL)

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THE SCHOOL COUNSELOR
AN ANALYSIS OF POST-TRAUMATIC STRESS DISORDER

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ABSTRACT

The authors recommend the development of a new prognostic PTSD diagnostic criteria specifically for children and adolescents.

**THE SCHOOL COUNSELOR:
AN ANALYSIS OF POST-TRAUMATIC STRESS DISORDER**

School counselors are confronted with a wide variety of problems and disorders in their social and academic environment. More frequently, the issues are Adjustment Disorders, career decision making and other anxiety issues. One of the most difficult areas to assess concerns anxiety disorders, in particular, Post-traumatic Stress Disorder. The Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) defines PTSD under the adult section and discusses some of the issues concerning children, but does not comment on adolescence. Moreover, the anxiety disorders are difficult to assess in childhood and adolescence because of overlapping symptoms.

Counselors should be alerted to some basic first order symptoms and problems associated with PTSD. The associated features of depression and anxiety are often present. Other issues are, persistent avoidance of the trauma, markedly diminished interest in significant activities in young children, and loss of recently acquired developmental skills such as toilet training or language skills (DSM-III-R p. 250). Central to this disorder is the problem of disassociative flashback, a sense of reliving the experience, illusions, hallucinations and sleep disturbances. In PTSD, we generally see symptoms of hypervigilence and exaggerated startle response.

It is unfortunate, that PTSD victims will suffer an additional burden of rejection from classmates (van der Kolk, 1985). They experience rejection from others because of the nature of their symptoms. Typically, they tend to be suspicious, depressed, apathetic and have a low tolerance for intimacy. Counselors should be especially sensitive and alert to second order problems created by their symptoms.

PTSD ASSESSMENT PROBLEMS

Symptoms concerning "Post-traumatic Stress Disorder" can be a problem area of assessment. The dysfunctions within the area of anxiety disorders of childhood or adolescence are considered to be specific to that particular age group. These are Separation Anxiety Disorder, Avoidant Disorder of Childhood or Adolescence and Overanxious Disorder. Diagnostic and Statistical Manual of Mental Disorders, the DSM-III-R defines these disorders and in addition, defines Anxiety Disorder and Obsessive Compulsive Disorder.

However, Post-traumatic Stress Disorder is found separately in the adult section, with a brief discussion of childhood symptoms. The experience of anxiety and its resultant effects is a major symptomatic component of this group of disorders. This separation of Post-traumatic Stress Disorder in the adult section contributes to the problem of assessment. Moreover, diagnosis is more difficult with children since partial syndromes and

overlapping subtypes may occur more commonly with childhood disorders (Flament et al., 1988).

The refinement of the Anxiety Disorders of Childhood or Adolescence would be useful in the development of future research. The category of Post-traumatic Stress Disorder in children deserves special emphasis in order to promote the importance of differential diagnosis. This disorder is provided for reactions to situations of extreme stress and psychological trauma that are beyond the range of normal experience. The DSM-III-R has included under the Adult Section more age-appropriate symptoms for children. For example, the repetitive play in young children in which themes or aspects of the trauma are expressed in reexperiencing the traumatic event. In young children, the loss of recently acquired developmental skills may be considered the equivalent to the adult symptoms of the numbing of general responsiveness (DSM-III-R, p. 349).

RESEARCH CONCERNS

Further research on the fundamental questions of differences or equivalence between childhood and adult Post-traumatic Stress Disorder may prove extremely useful concerning diagnostic procedures. The anxiety disorders have proven to be the most difficult group to diagnose reliably both in field trials and later in more focused research (Prendergast et al., 1988; Gittelman, 1986). The paucity of the data and research is reflected in the fact that a computer research of the Sociofile,

ERIC system, and Psyclit file produced only (8) directly related research articles for this topic within the past 12 years. This appears to be evidence concerning the limited research presently available on the topic of Post-traumatic Stress Disorder. This also presents serious concerns regarding PTSD issues directly related to childhood and adolescence, and is not a positive research trend that will benefit the treatment of children. The extent of the PTSD problem may be more profound than previously thought. Moreover, one researcher suggested that adolescence in comparison to young adulthood may be relatively more prone to PTSD disorder (van der Kolk, 1985).

Summary of Findings

Watson, (1990) explores the problems related to formal diagnosis of Post-traumatic Stress Disorder (PTSD), and the social implications of the concepts incorporated in the diagnosis. Problems with diagnosis include clinical difficulty in distinguishing between a normal psychological response to stress and an illness. Long term issues related to the social significance of PTSD include: (1) the psychosocial adjustment of adult victims, (2) the functioning of children experiencing extreme and catastrophic stress, and (3) the problems of children whose parents have PTSD. With the common findings in PTSD of constricted affect, hyperarousal and social withdrawal, PTSD could have a major impact on future generations.

Famularo (1990) conducted a recent study of medical records of 24 children diagnosed with acute Post-traumatic Stress Disorder (PTSD). Children with acute PTSD were found to have a significantly greater prevalence of symptoms such as: (1) nightmares and distressing dreams, (2) distress upon real or symbolic exposure, (3) difficulty in falling asleep, (4) hypervigilance (5) exaggerated startle response, and (6) generalized agitation/anxiety. Children with chronic PTSD, on the other hand, were found to have significantly greater difficulty with detachment or estrangement from others, expression of affect, pessimistic thinking and depression, and disassociative episodes.

Deblinger et al. (1989) reported on a comparative investigation of the rates of Post-traumatic Stress Disorder (PTSD) symptoms across sexually abused, physically abused, and nonabused psychiatrically hospitalized children. Each were matched for age, sex, and socioeconomic status. Among the sexually abused children, 20.7% met diagnostic criteria for PTSD, compared with 6.9% of the physically abused and 10.3% of the nonabused children. Although these overall rates were not significantly different across groups, they were sufficiently high enough to reinforce the need for further study of PTSD in childhood. Furthermore, significant symptoms rate differences across groups were found with respect to specific PTSD symptoms.

Specifically, sexually abused children exhibited significantly higher rates of inappropriate sexual behaviors than either the physically abused or nonabused children. In addition, both the sexually abused and physically abused groups tended to exhibit more avoidant/disassociative symptoms as compared to the nonabused children.

Conflicts in Diagnosis

In reviewing the ERIC system, it appears that two authors, Zelikoff and Hymen (1987), have presented papers at conferences expanding the PTSD definition for children. This expansion appears to be in contradiction with the DSM-III-R. The diagnostic criteria for 309.89 Post-traumatic Stress Disorder specifically states that: "The person has experienced an event that is outside the range of human experience and that would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity; serious threat to harm one's children, spouse, or other close relatives and friends; sudden destruction of one's home or community; or seeing another person who has recently been, or is being, seriously injured or killed as the result of an accident or physical violence." Zelikoff and Hyman (1987) reported that responses to the survey reveal incidence of verbal abuse and subsequent symptoms such as personality change, recollection of the traumatic incident, concentration difficulties, avoidant reactions, psychological

numbing, and physical problems. The survey further shows the longevity of symptoms and differences in the development of symptoms. In addition, the survey demonstrates that (1) demography influences the incidence of child abuse by teachers; (2) sarcasm, ridicule, voice-raising, criticism for low achievement, unjustified punishment, and restricting students from nonacademic activities are often identified as traumatic school stressors (Zelikoff and Hyman, 1987). The above mentioned behaviors do not meet the diagnostic criteria for PTSD because these events are not outside the range of usual human experience. These behaviors might be considered under the category of Adjustment Disorder or one of the other Phobic Disorders. Zelikoff and Hyman (1987) advocated that the PTSD requirement is inadequate and should include these behaviors because of the varying sensitivities of individuals. However, the DSM-III-R specifies that PTSD stressors would be markedly distressing to almost anyone. This position needs to be acknowledged in the literature as outside the boundaries of PTSD, or expanded to be included as part of the symptomology.

IMPLICATIONS FOR COUNSELORS

The authors recommend that a new Post-traumatic Stress Disorder and diagnostic procedure be developed for children. The symptoms would be specifically designed for children and assigned with the other anxiety disorders listed under Disorders Usually First Evident In Infancy, Childhood or Adolescence, Chapter III,

of the new DSM-IV. Significant DSM-III-R symptoms concerning children are presently listed on p. 249. This information and other research should be utilized to develop a conceptual approach that would meet the needs of children and adolescents and emphasize specific additional symptomatology.

DSM-III-R CRITERIA (CHILDREN)

The diagnostic criteria may be obstructed by the child that may be mute or refuse to discuss the trauma, but this should not be confused with the ability to remember what occurred. In addition, there may be a great deal of secrecy concerning the fantasies and the privacy of the acting out and play of children. The child may demonstrate recurrent and intrusive distressing recollections of the event. In young children, repetitive play in which themes or aspects of the trauma are expressed. In addition, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, or rescuing others, or of threats to self or others. Young children do not have the sense that they are reliving the past; reliving the trauma occurs in action, through repetitive play. A basic symptom of PTSD in children may be a marked change in orientation toward the future. This includes the sense of a foreshortened future, for example, a child may not expect to have a career or marriage. There may also be "omen formation", that is, belief in an ability to prophesy future events (DSM-II-R, p. 249). Moreover, their physical symptoms can confound the diagnosis.

The failure to pick-up on the PTSD symptoms can delay treatment that is essential to the positive growth, development and general welfare of children. A greater awareness of the specific symptoms should be established with a separate diagnostic criteria for children, listed under Chapter III.

ADOLESCENT ISSUES

Unfortunately, the DSM-III-R does not address adolescence and their particular symptomatic PTSD problems. The criteria to make a diagnosis is not specific. The emphasis is on the adult symptoms of PTSD, which does not provide a description to diagnose, study, and treat the PTSD in adolescence. While many of the diagnostic criteria apply in adolescence, the definition should specify more precisely related adolescent problems. It may prove useful in the future to develop an adolescent set of criteria for diagnostic and research purposes. At the present time, there is a need for further research in the area of adolescence. One of the few scholars to publish in this area, van der Kolk (1985), makes some valuable points concerning adolescent symptoms and reactions to PTSD. He identified several conceptual issues that may prove useful to school counselors. His study found that soldiers who developed post-traumatic stress disorder after combat in Vietnam tended to have been in adolescence while in combat. The loss of a "buddy" represents a narcissistic injury to which the survivor reacts with rage and retaliatory action rather than with grief and mourning.

The subsequent feelings of profound lack of control over their destiny is typical. The adolescent service members in Vietnam developed symptoms of post-traumatic stress which include difficulty in managing hostile and aggressive impulsives, especially when it was the loss of a close friend. The close peer relationships fostered an intense feeling or desire for revenge over the loss of a friend. Adolescents are particularly vulnerable for developing a primitive narcissistic need for gratification and power. Often there is retaliation and profound feelings of helplessness. Moreover, the transition between infantile dependence and adult autonomy is extremely difficult, thereby rendering adolescents more prone to PTSD.

Finally, adolescents will generally attempt to restore their sense of integrity by resorting to the fantasy of omnipotence. Should the process of individualization be impeded at this stage, we encounter all sorts of narcissistic pathology of which withdrawal from the world represents a real problem. Because of the nature of adolescence and object relations during the second individualization phase, this age group may be more predisposed to developing persistence symptoms of Post-traumatic Stress Disorder (van der Kolk, 1985).

CONCLUSION

The prescriptive approach to treatment requires an accurate diagnosis. Many of the changes in DSM-III and DSM-III-R have

proven quite helpful in the diagnosis of PTSD. The DSM-III-R includes specification of generic characteristics of traumatic stressors. The identification of symptoms are around three dimensions of stress responses: (1) reexperiencing avoidance, (2) numbing , (3) physiological arousal, and (4) the inclusion of symptoms specific to children. The next logical step is to refine the definition of PTSD for children and adolescents and list them appropriately with the other childhood anxiety disorders. This would serve a two-fold purpose: (1) to improve the diagnostic qualities, and (2) to improve the research data base. The treatment of children should be individualized on the basis of the diagnostic criteria and the needs of children. This position needs to be advocated by professional counselors and therapists working with children and adolescents. A natural progression from DSM-III-R to DSM-IV would be to define the diagnosis for Post-traumatic Stress Disorder for children and adolescents in a separate prognostic manner.

In conclusion, as early as 1920 Freud recognized that excessive trauma and stimulation can overwhelm the ego causing a variety of stress symptoms. An attempt was made in DSM-I (1952) to define and diagnose a category entitled Gross Stress Reaction. DSM-II (1968) redefined this category and seemed to prefer Adult Adjustment Reaction. The first use of the term Post-traumatic Stress Disorder was introduced in 1980 in DSM-III. Finally, in DSM-III-R, we have the most complete definition with acute,

chronic and/or delayed symptoms. The diagnosis is becoming more specific and descriptive in its evolutionary development. It is particularly important that the social concepts of childhood and adolescence PTSD be addressed through specific criteria refinement and research. This change is necessary so that we might provide for proper diagnosis, counseling, referral and prescriptive treatment for children and adolescents.

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